SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: Replacement AR	SERFF Tr Num: SEFL-126851674	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 47007
Sub-TOI: L08.000 Life - Other	Co Tr Num: REPLACEMENT AR	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Kristi Hendrickson	Disposition Date: 10/11/2010
	Date Submitted: 10/07/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Replacement AR	Status of Filing in Domicile: Not Filed
Project Number: Replacement AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/11/2010	Explanation for Other Group Market Type:
	State Status Changed: 10/11/2010
Deemer Date:	Created By: Kristi Hendrickson
Submitted By: Kristi Hendrickson	Corresponding Filing Tracking Number:

Filing Description:

Form Numbers Form Title

47-100-03351 (R09-10) Annuity Application

47-300-01101 (R09-10) Application for Simplified Life Insurance

47-352-05051 (R09-10) General Section

Assurity Life Insurance Company submits the above captioned forms for review and approval. The above stated forms are being revised in order to comply with Bulletin 1-2010. The only change being made is rewording of the statement below each replacement question.

SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Upon approval the above stated forms will replace their corresponding versions as shown below:

New Form Form to be replaced Approval
47-100-03351 (R09-10) 47-100-03351 12/11/2006
47-300-01101 (R09-10) 47-300-01101 (R03-08) 03/19/2008
47-352-05051 (R09-10) 47-352-05051 (R05-10) 08/03/2010

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist
1526 K Street
Lincoln, NE 68508

policyfiling@assurity.com
402-437-3452 [Phone]
402-437-3802 [FAX]

Filing Company Information

Assurity Life Insurance Company
1526 K Street
P.O. Box 82533
Lincoln, NE 68501-2533
(800) 276-7619 ext. [Phone]

CoCode: 71439
Group Code: -99
Group Name:
FEIN Number: 38-1843471

State of Domicile: Nebraska
Company Type: Life/Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	$150.00	10/07/2010	40411404

SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/11/2010	10/11/2010

SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Disposition

Disposition Date: 10/11/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Annuity Application		Yes
Form	Application for Simplified Life Insurance		Yes
Form	General Section of Application		Yes

SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Form Schedule

Lead Form Number: 47-100-03351 (R09-10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	47-100-03351 (R09-10)	Application/ Enrollment Form	Annuity Application	Revised	Replaced Form #: 47-100-03351 Previous Filing #:	50.000	47-100-03351 _R09-10_.pdf
	47-300-01101 (R09-10)	Application/ Enrollment Form	Application for Simplified Life Insurance	Revised	Replaced Form #: 47-300-01101 (R03-08) Previous Filing #: 38434	52.700	47-300-01101 _R09-10_.pdf
	47-352-05051 (R09-10)	Application/ Enrollment Form	General Section of Application	Revised	Replaced Form #: 47-352-05051 (R05-10) Previous Filing #: 46350	50.000	47-352-05051 _R09-10_.pdf

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Application for ANNUITY

PLEASE PRINT WITH BLACK INK

Select one: ☐ Plus One Annuity ☐ Secure 3 Annuity ☐ Secure 5 Annuity ☐ Secure 7 Annuity ☐ Encore Bonus Annuity ☐ Other _____ ☐ Single Premium Immediate Annuity

Select one: ☐ Non-qualified Annuity ☐ Simplified Employee Pension *(SEP)* ☐ Traditional Individual Retirement Annuity *(IRA)* ☐ Roth IRA ☐ Savings Incentive Match Program for Employees *(SIMPLE IRA)*

1. ANNUITANT *(Only one Annuitant for each application.)*

First *Middle* *Last* *(MM/DD/YYYY)*

Name | Date of Birth / /

Social Security No. | ☐ Male ☐ Female | Birth State/Country | Age

Street Address *City* *State* *ZIP+4*

Home Address

If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
If YES, please complete and return the appropriate State Replacement Form.

Does the Proposed Insured have other insurance coverage in force? ☐ Yes ☐ No
If YES, please provide details below.

Name of the company _____ Policy No.(s) _____

For SEP or SIMPLE Plan only, name of employer

2. OWNER *(Non-qualified only. Information needed only if Annuitant is not the Owner.)*

First *Middle* *Last* *(MM/DD/YYYY)*

Name | Date of Birth / /

Soc. Sec. or Tax I.D. No. | Relationship to Insured

Street Address *City* *State* *ZIP+4*

Home Address

3. SPOUSE AS JOINT-OWNER *(Non-qualified only.)*

First *Middle* *Last* *(MM/DD/YYYY)*

Name | Date of Birth / /

Social Security No. | Birth State/Country

Street Address *City* *State* *ZIP+4*

Home Address

4. BENEFICIARIES

If there is more than one Beneficiary, those surviving the deceased by 120 hours shall share benefits equally unless otherwise indicated.

Primary Beneficiary Name *(First, Middle, Last)*	Social Security No.	Relationship to Insured	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	

If no Beneficiary survives the deceased by 120 hours, benefits will be paid to the Contingent Beneficiary. When there is more than one Contingent Beneficiary, those surviving the deceased by 120 hours shall share benefits equally unless otherwise indicated.

Contingent Beneficiary Name *(First, Middle, Last)*	Social Security No.	Relationship to Insured	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	

5. PREMIUM INFORMATION

Single Premium *(must be $2,000 or over)* $ _____ *(If $500,000 or more, call the Investment Department for approval.)*

IRA only: ☐ Rollover Account ☐ Direct Transfer ☐ New Money

ROTH IRA: ☐ Conversion from Traditional IRA ☐ Transfer/Rollover from existing Roth ☐ New Money

6. SINGLE PREMIUM IMMEDIATE ANNUITY ONLY

Select a payment type below: ☐ **Yes**, withhold federal and state income taxes, if applicable, from the taxable distribution

☐ Left at Interest—payments will continue until the policy is terminated. The amount will vary depending on the amount of interest paid.

☐ Fixed Amount—payments will be determined by you and will continue until the amount originally applied is paid-in full Amount $ _____

☐ Fixed Period—payments will continue until the end of the fixed period selected Period _____ Years *(minimum 5 years)*

☐ Joint Last Survivor—payments will continue until the first spouse dies. Then a level or reduced payment will continue for the surviving spouse's lifetime. Survivor percentage _____ % *(100, 75 or 50)*

☐ Life Income Period Certain—payments will continue for a selected period or your life, if longer. Period _____ Years *(minimum 5 years)*

☐ Installment Refund—payments will continue as long as you are living or until the amount originally applied is paid-in-full.

☐ Life Only—payments will continue as long as you are living.

Substitute Form W-9 information *(Request for Taxpayer Identification No. and Certification)*: I, the Owner *(or each Joint Owner)*, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person *(including a U.S. resident alien)*. The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

IT IS AGREED that Assurity Life Insurance Company may rely upon the above statements as true representations to the best of my knowledge and belief.

Signed at _____ on _____ / _____ / _____
City *State* *Date (MM/DD/YYYY)*

_____ _____ _____
Signature of Proposed Annuitant *Signature of Joint Owner (Spouse)* *Signature of Owner (If other than Annuitant)*

_____ _____ _____
Signature of Witness *Signature of Licensed Agent* *Print Agent Name, Agent No. and Code*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

1. a. What amount was collected with this application? $ _____

   b. Did you personally witness the Proposed Annuitant(s) *(or Owner's if other than Annuitant)* signature on the application? ..... ☐ Yes ☐ No

   c. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all

2. If this insurance is issued, will it replace, modify or borrow against any existing or pending coverage? ..... ☐ Yes ☐ No

   Does any Proposed Insured have other insurance coverage in force? ..... ☐ Yes ☐ No

3. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ _____ % Agent No. _____ _____ %

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____ / / _____ ( ) — / ( ) —
Signature of Soliciting Agent *Date (MM/DD/YYYY)* *Business Phone No. and Fax No.*

_____ _____ _____
Soliciting Agent's Printed Name *Agent No.* *Agent's E-mail*

Special requests, remarks or instructions:

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402)476-6500 • (800)276-7619 • FAX (402)437-4591

Application for SIMPLIFIED LIFE INSURANCE

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

First / Middle / Last — Legal Name | Date of Birth (MM/DD/YYYY) / /

Social Security No. | ☐ Male ☐ Female | E-Mail | Age

Street Address / City / State / ZIP+4 — Home Address

Personal Phone No. ( ) | Birth State/ Country | Height ft. in. | Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type(s): Last date of use / / (MM/DD/YYYY)

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If YES, and you have permanent resident status, please list your permanent resident *(green card)* number:

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number:

2. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

First / Middle / Last — Legal Name | Date of Birth (MM/DD/YYYY) / /

Social Security No. | Relationship to Insured | Birth State/Country

Street Address / City / State / ZIP+4 — Home Address | E-Mail

3. BENEFICIARIES

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	
			/ /	
			/ /	

4. PREMIUM PAYMENT MODE

Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly *(Automatic)* ☐ List Bill

Payor Name First / Middle / Last | Relationship to Insured

Billing Address Street Address / City / State / ZIP+4 | Personal Phone No. ( )

5. GENERAL SECTION

1. In the past **2 years,** has the Proposed Insured been charged with or convicted of a felony? *(If YES, coverage cannot be issued.)*..... ☐ Yes ☐ No
2. Is the Proposed Insured currently negotiating for other insurance coverage? ..... ☐ Yes ☐ No
3. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?..... ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.
4. Does the Proposed Insured have other insurance coverage in force?..... ☐ Yes ☐ No
   If YES, please provide details below.

   Name of the company _____ Policy No. _____

6. HEALTH SECTION

Section A—If any question is answered YES, coverage cannot be issued.

1. Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less? ☐ Yes ☐ No

2. In the past **12 months,** has the Proposed Insured been medically diagnosed with diabetes or been treated for uncontrolled diabetes or any complications thereof, including numbness, amputation, circulation, eye or kidney disorder, coma or insulin shock; needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing, dressing, grooming, walking, managing medications)*; had or been advised to have brain, heart or circulatory surgery; had chronic respiratory disease such as chronic obstructive pulmonary disease *(COPD)* or emphysema; been treated with oxygen; been diagnosed with heart disease or had myocardial infarction *(heart attack)* or heart-related chest pain *(angina)*; or been confined to a nursing facility or received inpatient services at a medical facility for more than 48 continuous hours? ☐ Yes ☐ No

3. Has the Proposed Insured **ever** been medically diagnosed as having or been treated for *(including office visits, medication or surgery)*: leukemia, Hodgkin's disease, a blood or bleeding disorder, connective tissue disorder, Parkinson's disease, systemic lupus erythematosus *(SLE),* amyotrophic lateral sclerosis *(ALS),* cirrhosis, chronic hepatitis B, C or D, liver disease, kidney disease with dialysis treatment, Alzheimer's disease, dementia, lymphoma, lymph node enlargement or malignant melanoma; or received or been advised to receive an organ or tissue transplant; or in the past **5 years** been medically diagnosed with or been treated for internal cancer? ☐ Yes ☐ No

4. Has the Proposed Insured been medically diagnosed as having cerebral palsy, muscular dystrophy, cystic fibrosis, sickle cell anemia, Down's syndrome or congenital heart disease? ☐ Yes ☐ No

5. Has the Proposed Insured had a medical test and not yet received the results, or been advised to have surgery or receive medical treatment? ☐ Yes ☐ No

6. Has the Proposed Insured **ever** been medically diagnosed as having or been treated by a medical professional for acquired immune deficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*, or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ☐ Yes ☐ No

Section B—Complete only if all answers in Sections A were NO. Any YES answers in Section B limit consideration to Graded Benefit Whole Life coverage.

1. In the past **12 months**, has the Proposed Insured been medically diagnosed as having or been treated for: congestive heart failure or cardiomyopathy, stroke, aneurysm or sleep apnea; or had or been advised to have treatment for any drug or alcohol abuse? ☐ Yes ☐ No

2. In the past **5 years**, has the Proposed Insured had heart disease requiring bypass surgery, angioplasty or placement of stents or cardiac defibrillator? ☐ Yes ☐ No

3. Has the Proposed Insured **ever** been treated for *(including office visits, medication or surgery)*: diabetes requiring insulin injections combined with a medical history of stroke, transient ischemic attack *(TIA)* or heart disease*?* ☐ Yes ☐ No

If all questions in Sections A and B are answered NO, the Proposed Insured will be considered for Level Benefit Whole Life coverage.

7. POLICY INFORMATION

Plan of Insurance: ☐ Level Benefit Whole Life ☐ Graded Benefit Whole Life Initial Death Benefit $ _____

AGREEMENT

I, *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

1. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.
2. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: **a)** The application is approved by the Company at its home office, **b)** Such policy is issued and delivered to the Proposed Insured/Owner, and **c)** Such first full premium is paid during the Proposed Insured's lifetime and continued good health. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
3. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

Signed at _____ on _____ / _____ / _____
City *State* *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured *Signature of Owner(s) (If other than Proposed Insured)*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

1. a. What amount was collected with this application? $ _____

b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

2. a. Did you personally see the Proposed Insured on the date of application? ☐ Yes ☐ No

b. How well do you know the Proposed Insured? ☐ Well ☐ Slightly ☐ Not at all

c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? ☐ Yes ☐ No

If YES, please provide details _____

3. a. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

b. Does the Proposed Insured have other insurance coverage in force? ☐ Yes ☐ No

4. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ % Agent No. _____ %

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—signed authorization and voided check attached with the application.

☐ Add to existing bank withdrawal; indicate other applicant and/or policy numbers _____

☐ Set up NEW credit card payment—signed authorization attached with the application.

LIST BILL

☐ Set up NEW list bill—signed authorization attached with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	/ /	( ) / ( )
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name	*Agent No.*	*Agent's E-mail*
_____	/ /	( )
Signature of Second Soliciting Agent (if split commission)	*Date (MM/DD/YYYY)*	*Agent No.* *Business Phone No.*

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? ☐ Yes ☐ No

2. During the past **5 years** or within the next **12 months**:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? ☐ Yes ☐ No

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

3. During the next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? ☐ Yes ☐ No

   If YES, please explain _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, amount of weight change and reason for change:

   _____

5. During the past **5 years**, has any Proposed Insured:

   a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

   If YES, please explain _____

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

   If YES, please explain _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain _____

7. During the past **5 years**, has any Proposed Insured:

   a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or had more than 3 moving violations? ☐ Yes ☐ No

   If YES, please explain _____

   b. Been convicted of a felony? ☐ Yes ☐ No

   If YES, please explain _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

9. a. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

   If YES, provide details below.

   b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

   If YES, and applying for life or health coverage, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only	
						Coordinates w/ Soc. Sec.?	Employer Paid?
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No

10. **If the Proposed Insured is a juvenile,** please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
$	$	$	$	$	$	$

SERFF Tracking Number:	*SEFL-126851674*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*47007*
Company Tracking Number:	*REPLACEMENT AR*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Replacement AR*		
Project Name/Number:	*Replacement AR/Replacement AR*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

READ CERT-L.pdf

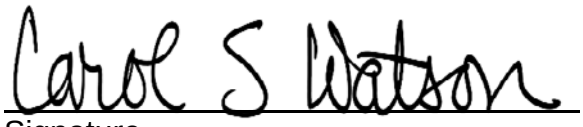
READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Type of Form: Life Applications

Form No.	Description	Flesch Score
47-352-05051 (R09-10)	General Section	50.0
47-100-03351 (R09-10)	Annuity Application	52.7
47-300-01101 (R09-10)	Application for Simplified Life Insurance	50.0



Signature

October 7, 2010
Date

Carol S. Watson
Vice President, General Counsel and Secretary